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GETTING ESSENTIAL DRUGS TO THE PEOPLE

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GETTING ESSENTIAL DRUGS TO THE PEOPLE

edited by Stuart Kingma

The health care services in many countries around the world are facing a period of considerable stress. In many cases this is the result of local and international conflicts and domestic violence which always make high demands on health services. Displacement of people and population shifts also bring pressure on services unprepared for large increases in numbers such as are seen in refugee camps, migration settlements and the rural-to-urban drift which is a continuing phenomenon. But in addition to these factors, the rising cost of supplies and staff salaries, the ruinous cost of energy and transportation and other inflation factors have led to cutbacks and a deterioration in many services.

A particularly serious aspect of this worldwide trend has been the severe, and in some cases worsening, shortage of essential drugs. This afflicts the poorer countries in a particular way; many developing countries are faced with shortages and empty shelves in their drugstores. The best estimates are now that, in the rural zone of a number of developing countries, 60 to 80% of the people have no access to even the most essential drugs. It is this problem which forms the focus of this issue of CONTACT and reflects a growing involvement by the CMC in efforts to alleviate this situation. Several facets of this problem make it a worthy one for a concerted attack at this time. First, it is the poor people who are the most affected by shortages of medicines. They often lack the basic drugs to treat the common, epidemic illnesses that take such a serious toll. Preventive measures and a truly effective primary health care programme are impossible without a dependable supply of essential pharmaceutical products.

Second, government health services as well as those of the churches and other voluntary agencies are finding that they do not have adequate resources to purchase sufficient quantities of essential drugs and maintain distribution to the remote parts of their countries. Dependency on commercial sources of supply has placed governments and nongovernmental organizations at the mercy of a seller's market

WHO photo by E. Schwab

"The pharmaceuticalization of care".

and the commercial pricing structures. For many developing countries, the ministry of health is obliged to allocate as much as 25 or even 50% of the annual recurrent health budget for the purchase of medicines from abroad. The people most affected by all this are those who cannot afford to purchase their medicines from the final step in the commercial chain, the local chemist shop.

Third, there is a growing concern that health care the world over is looking more and more to pharmaceutical answers to health and stress problems. This "pharmaceuticalization of care" can be seen within the healing professions as well as in the general public. Both parties to a medical consultation frequently refuse to accept the possibility that the body can heal itself or that a change in lifestyle or habits may be all that is needed for full restoration. The pattern seems to be that some pharmaceutical preparation is needed for every symptom and for every cure. Thus, in many health centres and clinics, even in the developing world, the average prescription will contain three to four different items; many of them are simply vitamins or antihistamines or tranquillizers which make little or no contribution to improving health but merely substitute for an inadequate relationship between therapist and patient. In one country, it was estimated that prescribing with care and only those things essentially needed could save up to 70% of the drug budget. Often, the cost of treating a patient in a teaching hospital goes many times higher as a result of prescribing expensive, non-life-saving drugs.

This pattern, as much as any other reason, accounts for the present difficulties in providing essential drugs. Studies of the pharmaceutical products marketed in various countries show that the number of different products available range from 2000 to more than 30,000 in a single country.

It is very clear that the time has come for a vigorous look at the need for an unequivocal drug policy by national governments and voluntary agencies.

The Search for a Functional Essential Drugs List

The concept of formulating an essential drugs list is not a new one. A number of agencies have been working on this for quite some time. Many church-related health programmes and a number of international agencies have already realized the necessity to impose the discipline of a restricted list of available products. Dating back some ten years, there have been discussions among Red Cross societies, church agencies, WHO and UNICEF on the shape that such an essential drugs list would take. The Director-General of WHO, at the meeting of the World Health Assembly in 1975, initiated a very specific programme to examine several aspects of drug policy.

One of the results of this most recent WHO programme has been the formation of an Expert Committee on the Selection of Essential Drugs. Two technical reports have emerged from this Committee, the first in 1977 and the second in 1979. The burden of these reports has been the proposal of a model list of essential drugs which can be used to frame a standard formulary, adapted to the specific health needs of a given population. The present list contains just over 200 active substances which can cover the health needs of the majority of the world's population. The list also contains a number of complementary drugs which are those recommended for the less common disorders. Each item in the list includes the required route of administration and the pharmaceutical forms and strengths of the preparations.

It should not be assumed that such a list is applicable only to developing countries. Physicians and other health workers everywhere tend to settle on a standardized list of their own ranging from 50 to 150 preparations which form the pharmaceutical range which they know well and use with safety. Experiments are under way in certain industrialized countries in which certain hospitals and group practices are imposing on themselves the discipline of using only those drugs on a restricted formulary. The experience of these groups, as well as government programmes in several developing countries, is that limited lists are well accepted and lead to favourable medical and economic results.

The use of such a list has several advantages. These have been itemized in the WHO Technical Report Series 615 (WHO, Geneva, 1977: "The Selection of Essential Drugs"):

1. Reduction in the number of pharmaceutical products to be purchased, stored, analysed, and distributed;

2. Improvement in the quality of drug utilization, management, information and monitoring;
3. Stimulation of local pharmaceutical industries;
4. Assistance to the least developed countries in urgent need of high-priority drug programmes to solve their primary health care problems.

The following principles were considered by the Expert Committee to be a foundation upon which to establish a list of essential drugs:

1. Adoption of a list of essential drugs is part of a national health policy. This implies that priority is given to achieving the widest possible coverage of the population with drugs of proven efficacy and safety, in order to meet the needs for prevention and treatment of the most prevalent diseases.
2. Only those drugs for which adequate scientific data are available from controlled studies should be selected.
3. Each selected pharmaceutical product must meet adequate standards of quality.
4. Concise, accurate and comprehensive drug information, drawn from unbiased sources, should accompany each list of essential drugs.

The presentation of a model list such as the one which follows is based on the principle that local needs and requirements will dictate the variations adopted in each local and national setting. These variations should be under the guidance of individuals competent in the areas of medicine and pharmacology, based on the results of a thorough study of local needs. The international non-proprietary *(generic)* names for drugs or pharmaceutical substances should be used whenever available and these names are best used when ordering pharmaceutical supplies. Reference to some mechanism for quality control is necessary and desirable. Cost, of course, represents a major selection criterion. In cost comparisons between drugs, the cost of the total treatment, and not only the unit cost must be considered. When two or more drugs are therapeutically equivalent, preference should be given to those which are most thoroughly investigated, have the most

WHO photo by A.S. Kocher

Hospital dispensary, Thailand.

WHO photo by A.S. Kocher

The campaign to control communicable diseases depends on the availability of vaccines such as this oral polio vaccine being administered by a government health worker.

favourable properties, exhibit the best stability in storage and which are the most readily available.

The following model list of essential drugs is taken from the WHO Technical Report Series 641 (World Health Organization, Geneva, 1979: "The Selection of Essential Drugs").

MODEL LIST OF ESSENTIAL DRUGS

Explanatory Notes

I. The numbers preceding the drug groups and subgroups in the model list (e.g., 11; 17.6.2) have been allocated, in accordance with the English alphabetical order, for convenience in referring to the various categories; they have no formal significance.

II. Numbers in parentheses following the drug names indicate:
- (1) Listed as an example of this therapeutic category: choose cheapest effective drug product acceptable;
- (2) Specific expertise, diagnostic precision or special equipment required for proper use;
- (3) Greater potency;
- (4) In renal insufficiency, contraindicated or dosage adjustments necessary;
- (5) To improve compliance;
- (6) Special pharmacokinetic properties for purpose;
- (7) Adverse effects diminish benefit/risk ratio;
- (8) Limited indications or narrow spectrum of activity;
- (9) For epidural anaesthesia;
- (10) Drugs subject to international control under the Single Convention on Narcotic Drugs (1961) and the Convention on Psychotropic Substances (1971).

III. Letters in parentheses following the drug names indicate the reasons for the inclusion of *complementary drugs:*
- (A) When drugs in the main list cannot be made available;

(B) When drugs in the main list are known to be ineffective or inappropriate for a given individual;

(C) For use in rare disorders or in exceptional circumstances.

IV. When the strength is specified in terms of a selected salt or ester, this is mentioned in brackets; when it refers to the active moiety, the name of the salt or ester in brackets is preceded by the word "as".

V. All drugs listed in this formulary are itemized by their *generic* names as an aid to encourage the use of generic names in prescribing and ordering medicines.

Main list	*Complementary drugs*	*Route of administration, pharmaceutical forms and strengths*
1. ANAESTHETICS		
1.1. General Anaesthetics and Oxygen		
ether, anaesthetic (2)		inhalation
halothane (2)		inhalation
nitrous oxide (2)		inhalation
oxygen		inhalation (medicinal gas)
thiopental (2)		powder for injection, 0.5 g, 1.0 g (sodium salt) in ampoule
1.2 Local Anaesthetics		
bupivacaine (1, 2, 9)		injection, 0.25%, 0.5% (hydrochloride) in vial
lidocaine (1)		injection, 1%, 2% (hydrochloride) in vial
		injection, 1%, 2% + epinephrine 1:100 000 in vial
		topical form 2-4% (hydrochloride)
2. ANALGESICS, ANTIPYRETICS, NONSTEROIDAL ANTIINFLAMMATORY DRUGS AND DRUGS USED TO TREAT GOUT		
acetylsalicylic acid		tablet, 100-500 mg
		suppository, 50-150 mg
allopurinol (4)		tablet, 100 mg
ibuprofen (1)		tablet, 200 mg
indometacin		capsule or tablet, 25 mg
paracetamol		tablet, 100-500 mg
		suppository, 100 mg
	colchicine (B, C) (7)	tablet, 0.5 mg
	probenecid (B, C)	tablet, 500 mg
3. ANALGESICS, NARCOTICS AND NARCOTIC ANTAGONISTS		
morphine (10)		injection, 10 mg (sulfate or hydrochloride) in 1-ml ampoule
naloxone		injection, 0.4 mg (hydrochloride) in 1-ml ampoule
	pethidine (A) (1, 4, 10)	injection, 50 mg (hydrochloride) in 1-ml ampoule
4. ANTIALLERGICS		
Antihistamines		
chlorphenamine (1)		tablet, 4 mg (maleate)
5. ANTIDOTES		
5.1 General		
charcoal, activated		powder
ipecacuanha		syrup, containing 0.14% ipecacuanha alkaloids calculated as emetine

Main list	*Complementary drugs*	*Route of administration, pharmaceutical forms and strengths*
	5.2 Specific	
atropine		injection, 1 mg (sulfate) in 1-ml ampoule
deferoxamine		injection, 500 mg (mesilate) in vial
dimercaprol (2)		injection in oil, 50 mg/ml in 2-ml ampoule
sodium calcium edetate (2)		injection, 200 mg/ml in 5-ml ampoule
sodium nitrite		injection, 30 mg/ml in 10-ml ampoule
sodium thiosulfate		injection, 250 mg/ml in 50-ml ampoule
	methylthioninium chloride (C) (Synonym: methylene blue)	injection, 10 mg/ml in 10-ml ampoule
	penicillamine (C) (2)	capsule or tablet, 250 mg
	6. ANTIEPILEPTICS	
diazepam		injection, 5 mg/ml in 2-ml ampoule
ethosuximide		capsule or tablet, 250 mg
phenobarbital (10)		tablet, 50 mg, 100 mg syrup, 15 mg/5 ml
phenytoin		capsule or tablet, 25 mg, 100 mg (sodium salt) injection, 50 mg (sodium salt)/ml in 5-ml vial
	carbamazepine (B, C)	tablet, 200 mg
	valproic acid (B, C) (2, 4, 7)	tablet, 200 mg (sodium salt)
	7. ANTIINFECTIVE DRUGS	
	7.1 Amoebicides	
metronidazole		tablet, 200-500 mg
	diloxanide (A)	tablet, 500 mg (furoate)
	emetine (A, B) (1, 7)	injection, 60 mg (hydrochloride) in 1-ml ampoule
	paromomycin (B)	capsule, 250 mg (as sulfate) syrup, 125 mg (as sulfate)/5 ml
	7.2 Anthelmintic Drugs	
mebendazole		tablet, 100 mg
niclosamide		tablet, 500 mg
piperazine		tablet, 500 mg (citrate or adipate) elixir or syrup (as citrate) equivalent to 500 mg hydrate/5 ml
tiabendazole		chewable tablet, 500 mg
	bephenium hydroxynaphthoate (B) (8)	granules, 5 g (equivalent to 2.5 g bephenium)
	7.3 Antibacterial Drugs	
ampicillin (1, 4)		capsule or tablet, 250 mg, 500 mg (anhydrous) powder for oral suspension, 125 mg (anhydrous)/5 ml powder for injection, 500 mg (as sodium salt) in vial
benzathine benzylpenicillin (5)		injection, 1.44 g benzylpenicillin (= 2.4 million IU)/5 ml in vial
benzylpenicillin		powder for injection, 0.6 g (= 1 million IU), 3.0 g (= 5 million IU) (as sodium or potassium salt) in vial
chloramphenicol (7)		capsule, 250 mg powder for injection, 1 g (as sodium succinate) in vial
cloxacillin (1)		capsule, 500 mg (as sodium salt) powder for injection, 500 mg (as sodium salt) in vial
erythromycin		capsule or tablet, 250 mg (as stearate or ethylsuccinate) oral suspension, 125 mg (as stearate or ethylsuccinate)/5 ml powder for injection, 500 mg (as lactobionate) in vial

Main list	*Complementary drugs*	*Route of administration, pharmaceutical forms and strengths*
gentamicin (4)		injection, 10 mg, 40 mg (as sulfate)/ml in 2-ml vial
metronidazole		tablet, 200-500 mg
phenoxymethylpenicillin		tablet, 250 mg (as potassium salt)
		powder for oral suspension, 250 mg (as potassium salt)/5 ml
salazosulfapyridine (2)		tablet, 500 mg
sulfadimidine (1, 4)		tablet, 500 mg
		oral suspension, 500 mg/5 ml
		injection, 1 g (sodium salt) in 3-ml ampoule
sulfamethoxazole + trimethoprim (4)		tablet, 100 mg + 20 mg, 400 mg + 80 mg
tetracycline (1, 4)		capsule or tablet, 250 mg (hydrochloride)
	amikacin (B, C) (1, 4)	injection, 250 mg (sulfate)/ml in 2-ml ampoule
	doxycycline (B) (5, 6)	capsule or tablet, 100 mg (as hydrochloride)
		injection, 100 mg (as hydrochloride)
	nitrofurantoin (A, B) (4, 7)	tablet, 100 mg
	procaine benzylpenicillin (A) (7)	powder for injection, 1 g (= 1 million IU)
		3 g (= 3 million IU)
7.4 Antifilarial Drugs		
diethylcarbamazine		tablet, 50 mg (citrate)
suramin sodium		injection, 1 g in vial
7.5 Antileprosy Drugs		
dapsone		tablet, 100 mg
	clofazimine (B)	capsule, 100 mg
	rifampicin (B)	capsule or tablet, 150 mg, 300 mg
7.6 Antimalarials		
chloroquine (1)		tablet, 150 mg (as phosphate or sulfate)
		syrup, 50 mg (as phosphate or sulfate)/5 ml
primaquine		tablet, 7.5 mg, 15 mg (as phosphate)
pyrimethamine		tablet, 25 mg
quinine		tablet, 300 mg (as bisulfate or sulfate)
		injection, 300 mg (as dihydrochloride)/ml in 2-ml ampoule or 250 mg (as formiate) in 1-ml ampoule
	sulfadoxine + pyrimethamine (B)	tablet, 500 mg + 25 mg
7.7 Antischistosomals		
metrifonate		tablet, 100 mg
niridazole (7, 8)		tablet, 100 mg, 500 mg
oxamniquine		capsule, 250 mg
		syrup, 250 mg/5 ml
	antimony sodium tartrate (B)	injection, 60 mg in 1-ml ampoule
	sodium stibocaptate (B)	injection, 500 mg
7.8 Antitrypanosomals		
melarsoprol (5)		injection, 3.6% solution
nifurtimox		tablet, 30 mg, 120 mg, 250 mg
pentamidine (5)		powder for injection, 200 mg (isetionate or mesilate)
suramin sodium		powder for injection, 1 g in vial
7.9 Antituberculosis Drugs		
ethambutol		tablet, 100-500 mg (hydrochloride)
isoniazid		tablet, 100 mg-300 mg
rifampicin		capsule or tablet, 150 mg, 300 mg
streptomycin (4)		injection, 1 g (as sulfate)

Main list	*Complementary drugs*	*Route of administration, pharmaceutical forms and strengths*
7.10 Leishmaniacides		
pentamidine (5)		powder for injection, 200 mg (isetionate or mesilate)
sodium stibogluconate		injection, 33%, equivalent to 10% antimony, in 30-ml vial
7.11 Systemic Antifungal Drugs		
amphotericin B		injection, 50 mg in vial
griseofulvin (8)		tablet or capsule, 125 mg, 250 mg
nystatin		tablet, 500 000 IU
	flucytosine (B) (1, 4, 8)	tablet or capsule, 250 mg
8. ANTIMIGRAINE DRUGS		
ergotamine (2, 7)		tablet, 2 mg (as tartrate)
9. ANTINEOPLASTIC AND IMMUNOSUPPRESSIVE DRUGS		
azathioprine (2)		tablet, 50 mg
		powder for injection, 100 mg (as sodium salt) in vial
bleomycin (2)		powder for injection, 15 mg (as sulfate) in vial
busulfan (2)		tablet, 2 mg
calcium folinate (2)*		tablet, 15 mg
		injection, 3 mg/ml in 10-ml ampoule
chlorambucil (2)		tablet, 2 mg
cyclophosphamide (2)		tablet, 25 mg
		powder for injection, 500 mg in vial
cytarabine (2)		powder for injection, 100 mg in vial
doxorubicin (1, 2)		powder for injection, 10 mg, 50 mg (hydrochloride) in vial
fluorouracil (2)		injection, 50 mg/ml in 5-ml ampoule
methotrexate (2)		tablet, 2.5 mg (as sodium salt)
		injection, 50 mg (as sodium salt) in vial
procarbazine (2)		capsule, 50 mg (as hydrochloride)
vincristine (2)		powder for injection, 1 mg, 5 mg (sulfate) in vial
10. ANTIPARKINSONISM DRUGS		
levodopa		tablet or capsule, 250 mg
trihexyphenidyl (1)		tablet, 2 mg, 5 mg (hydrochloride)
	levodopa + carbidopa (B) (1, 5, 6)	tablet, 100 mg + 10 mg, 250 mg + 25 mg
11. BLOOD, DRUGS AFFECTING THE		
11.1 Antianaemia Drugs		
ferrous salt (1)		tablet, equivalent to 60 mg iron (as sulfate or fumarate)
folic acid (2)		tablet, 1 mg
		injection, 1 mg in 1-ml ampoule
	iron dextran (B) (1, 5)	injection, equivalent to 50 mg iron/ml in 2-ml ampoule
hydroxocobalamin (1, 2)		injection, 1 mg in 1-ml ampoule

**Drug for "rescue therapy" with methotrexate.*

Main list	*Complementary drugs*	*Route of administration, pharmaceutical forms and strengths*
	11.2 Anticoagulants and Antagonists	
heparin (2)		injection, 1000 IU/ml, 25000 IU/ml in 5-ml ampoule
phytomenadione		injection, 10 mg/ml in 5-ml ampoule
protamine sulfate (2)		injection, 10 mg/ml in 5-ml ampoule
warfarin (1, 2, 6)		tablet, 5 mg (sodium salt)
	12. BLOOD PRODUCTS AND BLOOD SUBSTITUTES	
	12.1 Plasma Substitute	
dextran 70		injectable solution, 6%
	12.2 Plasma Fractions for Specific Uses	
albumin, human normal (2, 8)		injectable solution, 25%
	antihaemophilic fraction (C) (2, 8) (synonym: factor VIII)	(dried)
	fibrinogen (C) (2, 8)	(dried)
	plasma protein (C) (2, 8)	injectable solution, 5%
	factor IX complex (coagulation factors II, VII, IX, X, concentrate) (C) (2, 8)	(dried)
	13. CARDIOVASCULAR DRUGS	
	13.1 Antianginal Drugs	
glyceril trinitrate		tablet (sublingual) 0.5 mg
isosorbide dinitrate (1)		tablet (sublingual) 5 mg
propranolol (1)		tablet, 10 mg, 40 mg (hydrochloride) injection, 1 mg (hydrochloride) in 1-ml ampoule
	13.2 Antiarrhythmic Drugs	
lidocaine		injection, 20 mg (hydrochloride)/ml in 5-ml ampoule
procainamide (1)		tablet, 500 mg (hydrochloride) injection, 100 mg (hydrochloride)/ml in 10-ml ampoule
propranolol (1)		tablet, 10 mg, 40 mg (hydrochloride) injection, 1 mg (hydrochloride) in 1-ml ampoule
	quinidine (A, B) (1)	tablet, 200 mg (sulfate)
	13.3 Antihypertensive Drugs	
hydralazine (1)		tablet, 50 mg (hydrochloride)
hydrochlorothiazide (1)		tablet, 50 mg
propranolol (1)		tablet, 40 mg (hydrochloride)
sodium nitroprusside (1, 2, 8)		injection, 10 mg/ml in 5-ml vial
	methyldopa (A, B) (7)	tablet, 250 mg
	reserpine (A) (1, 7)	tablet, 0.1 mg, 0.25 mg injection, 1 mg in 1-ml ampoule
	13.4 Cardiac Glycosides	
digoxin (4)		tablet, 0.0625 mg, 0.25 mg oral solution, 0.05 mg/ml injection, 0.25 mg/ml in 2-ml ampoule
	digitoxin (B) (6)	tablet, 0.05 mg, 0.1 mg oral solution, 1 mg/ml injection, 0.2 mg in 1-ml ampoule

Main list	*Complementary drugs*	*Route of administration, pharmaceutical forms and strengths*
	13.5 Drugs Used in Shock or Anaphylaxis	
dopamine (2)		injection, 40 mg (hydrochloride)/ml in 5-ml vial
epinephrine		injection, 1 mg (as bitartrate) in 1-ml ampoule
	isoprenaline (c)	injection, 1 mg (hydrochloride)/ml in 2-ml ampoule
	14. DERMATOLOGICAL DRUGS	
	14.1 Antiinfective Drugs	
neomycin + bacitracin (1)		ointment, 5 mg neomycin + 500 IU bacitracin zinc/g
	14.2 Antiinflammatory Drugs	
betamethasone (1, 3)		ointment or cream, 0.1% (as valerate)
hydrocortisone (1)		ointment or cream, 1% (acetate)
	14.3 Astringents	
aluminium acetate		solution 13% for dilution
	14.4 Fungicides	
benzoic acid + salicylic acid		ointment or cream, 6% + 3%
miconazole (1)		ointment or cream, 2% (nitrate)
nystatin		ointment or cream 100 000 IU/g
	14.5 Keratoplastic Agents	
coal tar		solution, topical 20%
salicylic acid		solution, topical 5%
	14.6 Scabicides and Pediculicides	
benzyl benzoate		lotion, 25%
gamma benzene hexachloride		cream or lotion, 1%
	15. DIAGNOSTIC AGENTS	
edrophonium (2, 8)		injection, 10 mg (chloride) in 1-ml ampoule
tuberculin, purified protein derivative (PPD)		injection
	15.1 Ophthalmic	
fluorescein		eye drops, 1% (sodium salt)
	15.2 Radiocontrast Media	
adipiodone meglumine (1)		injection, 25% in 20-ml vial
barium sulfate (1)		powder
iopanoic acid (1)		tablet, 500 mg
meglumine amidotrizoate (1)		injection, 60% in 20-ml ampoule
sodium amidotrizoate (1)		injection, 50% in 20-ml ampoule
	16. DIURETICS	
amiloride (1)		tablet, 5 mg (hydrochloride)
furosemide (1)		tablet, 40 mg
		injection, 10 mg/ml in 2-ml ampoule
hydrochlorothiazide (1)		tablet, 50 mg
mannitol		injectable solution, 10%, 20%
	chlortalidone (b) (6)	tablet, 50 mg

Main list	*Complementary drugs*	*Route of administration, pharmaceutical forms and strengths*
		17. GASTROINTESTINAL DRUGS
		17.1 Antacids (nonsystemic)
aluminium hydroxide		tablet, 500 mg
		oral suspension, 320 mg/5 ml
magnesium hydroxide		oral suspension, equivalent to 550 mg magnesium oxide/10 ml
	calcium carbonate (A, B)	tablet, 600 mg
		17.2 Antiemetics
promethazine (1)		tablet, 10 mg, 25 mg (hydrochloride)
		elixir or syrup, 5 mg (hydrochloride)/5 ml
		injection, 25 mg (hydrochloride)/ml in 2-ml ampoule
		17.3 Antihaemorrhoidals
local anaesthetic, astringent and antiinflammatory drug (1)		ointment or suppository
		17.4 Antispasmodics
atropine (1)		tablet, 1 mg (sulfate)
		injection, 1 mg (sulfate) in 1-ml ampoule
		17.5 Cathartics
senna (1)		tablet, 7.5 mg (sennosides)
		17.6 Diarrhoea
		17.6.1 Antidiarrhoeal
codeine (1, 10)		tablet, 30 mg (phosphate)
		17.6.2 Replacement Solution
oral rehydration salts (for glucose-salt solution)		
For 1 litre of water:		(sachet) mmol/l
sodium chloride (table salt)		3.5 g, Na^+ 90
sodium bicarbonate (baking soda)		2.5 g, HCO_3^- 30
potassium chloride		1.5 g, K^+ 20
glucose (dextrose)		20.0 g, glucose 111
		18. HORMONES
		18.1 Adrenal Hormones and Synthetic Substitutes
dexamethasone (1)		tablet, 0.5 mg, 4 mg
		injection , 4 mg (sodium phosphate) in 1-ml ampoule
hydrocortisone		powder for injection, 100 mg (as sodium succinate) in vial
prednisolone (1)		tablet, 5 mg
	fludrocortisone (C)	tablet, 0.1 mg (acetate)
		18.2 Androgens
testosterone (2)		injection, 200 mg (enantate) in 1-ml ampoule
		injection 25 mg (propionate) in 1-ml ampoule
		18.3 Estrogens
ethinylestradiol (1)		tablet, 0.05 mg

Main list	*Complementary drugs*	*Route of administration, pharmaceutical forms and strengths*
18.4 Insulins		
compound insulin zinc suspension (1)		injection, 40 IU/ml in 10-ml vial, 80 IU/ml in 10-ml vial
insulin injection		injection, 40 IU/ml in 10-ml vial, 80 IU/ml in 10-ml vial
18.5 Oral Contraceptives		
ethinylestradiol + levonorgestrel (1)		tablet, 0.03 mg + 0.15 mg, 0.05 mg + 0.25 mg
ethinylestradiol + norethisterone (1)		tablet, 0.05 mg + 1.0 mg
	norethisterone (B)	tablet, 0.35 mg
18.6 Progestogens		
norethisterone (1)		tablet, 5 mg
18.7 Thyroid Hormones and Antagonists		
levothyroxine		tablet, 0.05 mg, 0.1 mg (sodium salt)
potassium iodide		tablet, 60 mg
propylthiouracil (1)		tablet, 50 mg
18.8 Ovulation Inducer		
	clomifene (C) (2, 8)	tablet, 50 mg (citrate)
19. IMMUNOLOGICALS		
19.1 Sera and Immunoglobulins		
anti-D immunoglobulin (human)		injection, 0.25 mg/ml
antirabies hyperimmune serum		injection, 1000 IU in 5-ml ampoule
antivenom sera		injection
diphtheria antitoxin		injection, 10 000 IU, 20 000 IU in vial
immunoglobulin, human normal (2)		injection
tetanus antitoxin		injection, 50 000 IU in vial
19.2 Vaccines		
19.2.1 For Universal Immunization		
BCG vaccine (dried)		injection
diphtheria-pertussis-tetanus vaccine		injection
diphtheria-tetanus vaccine		injection
measles vaccine		injection
poliomyelitis vaccine (live attenuated)		oral solution
smallpox vaccine		multiple puncture
tetanus vaccine		injection
19.2.2 For Specific Groups of Individuals		
influenza vaccine		injection
meningococcal vaccine		injection
rabies vaccine		injection
typhoid vaccine		injection
yellow fever vaccine		injection

All vaccines should comply with the WHO Requirements for Biological Substances*

** Requirements for specific vaccines and their standards are available in various WHO Technical Reports, available on request from the WHO, Geneva.*

Main list	*Complementary drugs*	*Route of administration, pharmaceutical forms and strengths*
20. MUSCLE RELAXANTS (PERIPHERALLY ACTING) AND CHOLINESTERASE INHIBITORS		
neostigmine (1)		tablet, 15 mg (bromide)
		injection, 0.5 mg (metilsulfate) in 1-ml ampoule
suxamethonium (2)		injection, 50 mg (chloride)/ml in 2-ml ampoule
tubocurarine (1, 2)		injection, 10 mg (chloride)/ml in 1.5-ml ampoule
	pyridostigmine (B) (2, 8)	tablet, 60 mg (bromide)
		injection, 1 mg (bromide) in 1-ml ampoule
21. OPHTHALMOLOGICAL PREPARATIONS		
21.1 Antiinfective		
silver nitrate		solution (eye drops) 1%
sulfacetamide		eye ointment, 10% (sodium salt)
		solution (eye drops), 10% (sodium salt)
		eye ointment, 1% (hydrochloride)
21.2 Antiinflammatory		
hydrocortisone (2, 7)		eye ointment, 1% (acetate)
21.3 Local Anaesthetics		
tetracaine (1)		solution (eye drops), 0.5% (hydrochloride)
21.4 Miotics		
pilocarpine		solution (eye drops), 2%, 4% (hydrochloride or nitrate)
21.5 Mydriatics		
homatropine (1)		solution (eye drops), 2% (hydrobromide)
	epinephrine (A, B) (2)	solution (eye drops), 2% (as hydrochloride)
21.6 Systemic		
acetazolamide		tablet, 250 mg
22. OXYTOCICS		
ergometrine (1)		tablet, 0.2 mg (maleate)
		injection, 0,2 mg (maleate) in 1-ml ampoule
oxytocin		injection, 10 IU in 1-ml ampoule
23. PERITONEAL DIALYSIS SOLUTION		
intraperitoneal dialysis solution (of appropriate composition)		parenteral solution
24. PSYCHOTHERAPEUTIC DRUGS		
amitriptyline (1)		tablet, 25 mg (hydrochloride)
chlorpromazine (1)		tablet, 100 mg (hydrochloride)
		syrup, 25 mg (hydrochloride)/5 ml
		injection, 25 mg (hydrochloride)/ml in 2-ml ampoule
diazepam (1)		tablet, 5 mg
fluphenazine (1, 5)		injection, 25 mg (decanoate or enantate) in 1-ml ampoule
haloperidol (1)		tablet, 2 mg
		injection, 5 mg in 1-ml ampoule
lithium carbonate (2, 4, 7)		capsule or tablet, 300 mg

Main list	*Complementary drugs*	*Route of administration, pharmaceutical forms and strengths*
25. RESPIRATORY TRACT, DRUGS ACTING ON THE		
25.1 Antiasthmatic Drugs		
aminophylline (1)		tablet, 200 mg
		injection, 25 mg/ml in 10-ml ampoule
epinephrine		injection, 1 mg (as hydrochloride) in 1-ml ampoule
salbutamol (1)		tablet, 4 mg (sulfate)
		oral inhalation (aerosol), 0,1 mg (sulfate) per dose
		syrup, 2 mg (sulfate)/5 ml
	beclometasone (B) (8)	oral inhalation (aerosol), 0.05 mg (dipropionate) per dose
	cromoglicic acid (B) (2, 8)	oral inhalation (cartridge), 20 mg (sodium salt) per dose
	ephedrine (A)	tablet, 30 mg (as hydrochloride)
		elixir, 15 mg (as hydrochloride)/5 ml
		injection, 50 mg (sulfate) in 1-ml ampoule
25.2 Antitussives		
codeine (10)		tablet, 10 mg (phosphate)
26. SOLUTIONS CORRECTING WATER, ELECTROLYTE AND ACID-BASE DISTURBANCES		
26.1 Oral		
oral rehydration salts (for glucose-salt solution)		For composition, see 17.6.2 *Replacement solution*
potassium chloride		oral solution
26.2 Parenteral		
compound solution of sodium lactate		injectable solution
glucose		injectable solution, 5% isotonic, 50% hypertonic
glucose with sodium chloride		injectable solution, 4% glucose, 0.18% sodium chloride (Na^+ 30 mmol, Cl^- 30 mmol/l)
potassium chloride		injectable solution
sodium bicarbonate		injectable solution, 1.4% isotonic (Na^+ 167 mmol/l, HCO_3^- 167 mmol/l)
sodium chloride		injectable solution, 0.9% isotonic (Na^+ 154 mmol/l, Cl^- 154 mmol/l)
water for injection		in 2-ml, 5-ml, 10-ml ampoules
27. SURGICAL DISINFECTANTS		
chlorhexidine (1)		solution, 5% (gluconate) for dilution
iodine (1)		solution, 2.5%
28. VITAMINS AND MINERALS		
ascorbic acid		tablet, 50 mg
ergocalciferol (1)		capsule or tablet, 1.25 mg (50 000 IU)
		oral solution, 0.25 mg/ml (10 000 IU)
nicotinamide (1)		tablet, 50 mg
pyridoxine		tablet, 25 mg (hydrochloride)
retinol		capsule or tablet, 7.5 mg (25 000 IU), 60 mg (200 000 IU)*
		oral solution, 15 mg/ml (50 000 IU)
riboflavin		tablet, 5 mg
sodium fluoride		tablet, 1.1 mg
thiamine		tablet, 50 mg (hydrochloride)
	calcium gluconate (C) (2, 8)	injection, 100 mg/ml in 10-ml ampoule

**For use in the treatment of xerophthalmia with a single dose, not to be repeated before 4 months have elapsed.*

WHO photo by D. Henrioud

Rural health unit dispensary in Tanzania.

Suggested Formulary for Community Health Care Centres

For the smaller, more peripheral units in any health system, a more limited list will certainly be appropriate. The length of such a list will be determined by the training and capacity of the type of health worker assigned to each health unit. The medicines required will also be determined by the kind of programme which is carried out at the community health centre. If the staff working in such a health unit are qualified to give injections, the various vaccines in a standard immunization programme would be among those basic essential drugs appropriate to that centre. If the care of tuberculosis patients is carried out at a given community health centre, the standard two or three drugs for first-line therapy would also be made available to that health unit.

The composition of a limited formulary of a community health centre is best determined by those with responsibility for supervision and the training of its workers. It has been suggested by a number of people who have studied this situation that the community-based, primary health care unit can be safely and adequately managed with a selection of twenty of the most essential drugs. The list which follows is longer than twenty, but it draws upon the experience of a number of groups and offers a range within which selections could be made. This list, compiled by the CMC, is again simply a guide and model, and the specific circumstances will determine which drugs are chosen and whether others from the main WHO list need to be added.

SUGGESTED BASIS FOR SELECTION
OF DRUGS TO CONSTITUTE COMMUNITY HEALTH CARE CENTRE FORMULARY

acetylsalicylic acid
paracetamol
metronidazole
mebendazole
piperazine
ampicillin
sulfadimidine
tetracycline
diethylcarbamazine
chloroquine
pyrimethamine
isoniazid
streptomycin
ferrous salt
folic acid
hydroxocobalamin
neomycin + bacitracin skin ointment
benzoic acid + salicylic acid skin ointment
benzyl benzoate
aluminium hydroxide
promethazine
senna
oral rehydration salts (for glucuose-salt solution)
BCG vaccine
diptheria-pertussis-tetanus vaccine
measles vaccine
poliomyelitis vaccine (live attenuated)
tetanus vaccine
silver nitrate eye drops
sulfacetamide eye ointment
ergometrine
iodine
ascorbic acid
ergocalciferol

It will be noted that in the drug lists that have been itemized, there has been no reference to traditional or herbal medicines, which are still in very common use in many countries. For a full discussion of this topic, see CONTACT No. 58, October 1980. Where their preparation is standardized, their potency and contraindications are known and their use carried out by those familiar with their properties, many of these preparations can be helpful for symptomatic care.

First-line Drugs for Emergency Relief in Natural Disasters

The management of the medical problems of victims of natural disasters requires a relatively specific line of pharmaceutical preparations. The literature is full of reports which illustrate the problems which have been experienced by those serving in the capacity of emergency disaster relief workers. Frequently, the medicines provided are innappropriate and en-

World Council of Churches photo by John Fulton

A shipment of medical supplies arrives for use by emergency disaster relief team in Sudan.

compass a wide diversity of poorly identified drugs. Disaster health teams often have to deal with large containers packed with tiny sample medicine bottles of a wide variety of preparations. "Supplies" of this sort demand the diversion of the time and energies of relief workers to sort and classify and group these many preparations and delay the actual application of appropriate health services.

The Pan American Health Organization carried out a study of the drugs required in these circumstances and provided a provisional list of first-line drugs based on their recognized efficacy, low cost, sufficient shelf life and logistic convenience. The following list is taken from the "Disaster Prepardness in the Americas" newsletter, Issue No 4, March 1980.

PROVISIONAL LIST
OF FIRST-LINE DRUGS FOR EMERGENCY RELIEF IN DISASTER SITUATIONS

1. Adrenalin (Epinephrine) 1:1000
2. Aminophylline, 200 mg tablets
3. Ampicillin, 250 mg capsules
4. Ophthalmic antibiotic ointment
5. Antiseptic ointment (cetrimide)
6. Aspirin, 500 mg tablets
7. Atropine sulphate Inj., 0.5 mg/ml
8. Chloramphenicol, 250 mg capsules
9. Chloroquine syrup, 50 mg/ml
10. Chloroquine, 150 mg tablets
11. Digoxin, 250 microgram tablets
12. Dextrose Inj. 25%, 50 ml
13. Emetine hydrochloride Inj., 60 mg/ml
14. Ergometrine maleate 2 mg tablets
15. 5% Isotonic glucose solution, 500 ml
16. Glyceryl trinitrate, 0.5 mg sublingual tablets
17. Tincture of iodine, 2.5%
18. Lidocaine HCL, 1% solution
19. Lidocaine HCL, 2% solution
20. Neostigmine methylsulphate Inj., 0.25 mg
21. Normal saline solution, 500 ml
22. Oral rehydration salts
23. Penicillin G 300,000 units
    Procaine penicillin 300,000 units
    Benzathine penicillin 600,000 units
24. Penicillin-V, 250 mg tablets
25. Phenobarbital, 30 mg tablets
26. Prednisolone, 5 mg tablets
27. Promethazine HCL, 25 mg tablets
28. Sulfadimidine, 500 mg tablets
29. Tetracycline HCL, 250 mg capsules
30. Oxytetracycline syrup, 125 mg/ml
31. Sodium thiopental Inj., 1 g vial
32. Zinc oxide ointment, 450 g
33. Sodium cloxacillin, 50 mg capsules
34. Erythromycin stearate, 250 mg
35. Pethidine Inj., S.C./I.M./I.V.
36. Cetrimide Liq. WNC 40%
37. Distilled water, 10 ml
38. Metronidazole, 250 mg tablets
39. Soap in bars
40. Burn Dressing Petrolatum
41. Tetanus Toxoid Inj.

CMC NEWS

Southeast Asia Consultation on The Christian Understanding of Health, Healing and Wholeness

Dhyana Pura, Bali, 25 April – 1 May 1981

Once again, the scene was set. Coming together at the invitation of the Christian Medical Commission, this time in Bali in April 1981, were 44 participants and 4 observers from 6 countries of Southeast Asia: Indonesia, the Philippines, Malaysia, Thailand, Singapore and Burma. Also present were some CMC commissioners, representatives from other sub-units of the WCC and staff of the CMC. Some months of sounding out the existing "study network"* in the region had yielded information on a number of people, medical, lay and clergy, whose work is a living witness to the church's healing ministry, whether through caring for people's health, their spiritual wellbeing, or working with them in other social or developmental areas. Now, for the fifth time since 1979, CMC was making it possible for a very diverse group of workers in these fields to discover that others like themselves are struggling to improve the conditions and quality of life of their communities and, particularly, of poor people. For participants often working in total

* People already in touch with CMC on a number of topics related to the theme of its Study/Enquiry on The Christian Understanding of Health, Healing and Wholeness.

isolation, just making this discovery was a source of inspiration which alone would have justified the consultation. Add to this not only the benefits of sharing experiences and information, but also that of being able to discuss subjects of common concern and trying, with others, to formulate a coherent philosophy of health, healing and wholeness, and one can better appreciate what this consultation meant and was able to achieve.

In comparison to previous CMC regional consultations (see CONTACT No 51, June 1979, No 54, December 1979 and No 59, December 1980) in the Caribbean, Central America, Africa and Southern Asia, a distinctive feature of the Southeast Asia meeting was the great diversity of political, cultural and social backgrounds of the participants from different countries. Dialogue in national groups helped to crystallize thinking and was a first step towards formulating some tentative regional strategies at the close of the consultation. Most of these groups felt, however, that since the message of community-based health care had not really "percolated through" in their own countries, only a modest beginning could be made in devising regional strategies. Participants set national goals for information exchange, conscientization and motivation, education and training and the use and coordination of all local community, church and government resources for health.

As in previous regional consultations, the participants in the Southeast Asia meeting also split into a number of interest groups to study themes they themselves had identified. CMC had taken care not to supply the participants with a great deal of information on what *others* had said and thought on the subject of health, healing and wholeness, i.e., with a ready-made set of concepts which might discourage a genuine search for understanding. The participants were thus enabled — together and in their interest groups — to seek an understanding and formulations which would be an authentic expression of their own experiences and situation. While many had been working in health and development on the basis of an implicit, even unconscious, philosophy and beliefs, these may never have been articulated before, perhaps simply due to lack of an opportunity to discuss such topics with others. Thus, it could be said that the second characteristic of the Southeast Asia consultation was that it was an *authentic struggle* by the participants to understand what health, healing and wholeness mean in their own countries and region and, in turn, what this implies for their work.

In other ways, the consultation resembled previous ones in the CMC study cycle. There was a grappling with definitions of health and wholeness. Health was seen as "a state of physical, mental and social wellbeing, in harmony with others, with the environment and with God"; healing as "a process whereby the individual is made whole and restored to a right relationship with others, with the environment and with God". There was an attempt to raise all the factors having an adverse effect on people's health and these were related to poverty, social injustice and lack of coordination and misuse of resources. It was recognized that the churches are not dealing satisfactorily with these problems. There was an effort to identify strategies to overcome the problems and to bring health and wholeness to the people of the region. Strategies suggested included interchurch and church/government cooperation, community-based health care, community participation and the use of all local resources in promoting self-reliance, recognizing traditional, charismatic and other alternative forms of healing. And finally, the participants were clear that these themes have far-reaching implications for a new vision of the mission and ministry of the church and the congregation.

Recommendations coming out of a final plenary discussion on regional strategies related to continuing friendships made at the meeting as well as information sharing, the possibility of follow-up meetings, of exchanging personnel of forming Christian medical associations in the various countries first with a view to regional cooperation and of combining to deal with the activities of pharmaceutical TNCs in the region.

* * *

THE ANNUAL MEETING OF THE CHRISTIAN MEDICAL COMMISSION

2-8 May 1981
Dhyana Pura, Bali, Indonesia

Certain themes which continue to surface at meetings of the Christian Medical Commission were again the focus of reflection and discussion as CMC commissioners, staff and guests met at the Dhyana Pura guest house of the Protestant Church in Bali. Such issues and questions as the following colour the daily reality of commissioners as they work in church-related health care services:

- the meaning of health, healing and wholeness
- the theological basis for the Christian involvement in health care (and commitment to the poor)
- the relationship of health to development
- the unavailability or at least inaccessibility of a basic "floor" of health care and the insurmountable barriers to meeting their basic needs, which is the lot of the majority of the world's population
- severe shortages going as far as a complete breakdown in supplies of essential basic drugs in many developing countries
- how to achieve people's/congregations'/communities' participation in health care; community motivation and organization
- self-reliance in community-based primary health care programmes.

Commission meetings provide a cherished opportunity to share insights, create a common vision and hammer out a common strategy to deal with these realities.

The recurrence of these themes is only an indication of the magnitude of the needs, of the problems and barriers to, and the depth of the commissioners' commitment to, enabling people to realize their own health, healing and wholeness.

The urgency of these questions and the need to crystallize its thinking on priorities and strategies for the next two years, as well as to leave a "legacy" for the next CMC, were the keynotes of the Bali meeting, since it was not only the last meeting of the present Commission, constituted in 1976 for six years, but also the last meeting of the CMC under its current mandate, due to be reviewed in the two years prior to the next full Assembly of the World Council of Churches (WCC) in Vancouver in 1983.

Reworking a position paper on "The Churches' Commitment to the Poor — Implications for the Healing Ministry", which came out of the last annual Commission meeting in Cyprus in April 1980, was one avenue through which the commissioners could express their ideas and concerns.

Commissioners also stressed the need, in setting priorities and strategies, to be realistic in terms of taking into account CMC's small staff and of using its resources, particularly its commissioners, to best effect. Two priorities for CMC work were identified for the period until its mandate ends:

1. Understanding and disseminating the concept of health, healing and wholeness.
2. Primary health care (PHC).

In its work of gaining and enabling a better understanding of health, healing and wholeness, CMC should make an effort to promote awareness-raising, the congregation's role in healing, the churches' involvement with vulnerable groups; it should emphasize the mental/social/spiritual/moral components of health, and should continue to help the churches to set their health care priorities.

In enabling, promoting and supporting PHC, the emphasis should be on training health personnel; the production and equitable distribution of low-cost drugs, and drug control; on collaboration between groups; on the role of the hospitals as an expandable base for services; on justice and health care; on financing health care and on the availability and equitable distribution of health care resources; and on self-care and responsibility of each person for his/her own health.

Other issues which the commissioners saw as coming under both priority areas were involvement with disabled persons; humanization of health care; women and health; and concern for those who are not financially poor.

Strategies recommended to implement these priorities included: defining and strengthening the role of commissioners; organizing meetings of regional coordinators of church-related health work; studying and following up the

regional consultations held within the framework of the CMC Study/Enquiry on the Christian Understanding of Health, Healing and Wholeness; developing resource materials; strengthening the national coordinating agencies for church-related health services which CMC helped to found and helping them to evaluate their work; and the training of health personnel.

The commissioners took an active part in preparing a major presentation on the activities and goals of the CMC to the meeting of the Central Committee of the World Council of Churches in Dresden in August 1981. An additional part of their work was the framing of a number or resolutions on the continuation of the CMC Study/Enquiry and the completion of its Study on the Financing of Community Health Care Programmes.

Throughout the two meetings described above, participants, CMC commissioners, staff and guests greatly appreciated the care and concern with which representatives of the Protestant Church of Bali took care of their comfort and all the local arrangements. The Dhyana Pura guest house, which is also a vocational training centre for young people, provided a beautiful and restful setting for the meetings. The programmes planned by the Church allowed opportunities for contacts between participants from other countries in the region, CMC members, staff and friends, and Bali church and congregation members. They included festive evenings together and visits to a number of small village congregations and to churches in Denpasar to join their Sunday workshop services. These events helped participants, commissioners, staff and friends to gain insights into the situation and work of the Protestant Church in Bali.

NEW PUBLICATIONS

Appropriate Technology Sourcebook
Volume Two, by Ken Darrow, Kent Keller & Rick Pam. 1981 496 pages

Briefly mentioned some time ago in CONTACT, this book has now come out in a second volume. These annotated, illustrated books are written for use by individuals and groups around the world who are looking for clearly presented, basic technical books and plans on village technology topics. Volume Two reviews 500 recent books on village-scale tools, equipment and techniques in such areas as renewable energy sources, agriculture, low-cost housing, transportation, fish farming, forestry, water supply and sanitation. A chapter on health care reviews village health worker manuals and teaching materials. Chapters on non-formal education, local communications, small enterprises and strategies for self-reliance tackle issues of approach and scale, based on the realization that appropriate technologies can best take root and flourish within community structures.

Prices: $ 6.50 paperback
$ 3.25 paperback to local groups in developing countries
$ 11.50 clothbound
Postage: $ 1.50 surface mail

Orders should be addressed to:
Appropriate Technology Project
Volunteers in Asia
PO Box 4543
Stanford, California 94305
USA

The Economics of Disability: International Perspectives
Susan Hammerman &
Stephen Maikowski, Editors 1981 238 pages

The economic and social costs of disability; levels of government expenditure on rehabilitation; the impact of disability on the family and income; the costs and benefits of disability prevention; the costs of not providing rehabilitation services; economies in the provision of rehabilitation services; labour market policies for disabled people; disability benefit systems; and cost benefit methodology and its application to the rehabilitation process — these and other facets of the economics of disability and rehabilitation are dealt with in this book, brought out by Rehabilitation International in cooperation with the United Nations.

"The Report shows clearly that investment in well-organized, efficient rehabilitation services not only helps disabled persons to become active members of society but also, in the final analysis, leads to savings to national economies, since rehabilitation means increased utilization of important human resources."

Price: $ 15.00

Orders should be sent to:
Rehabilitation International
432 Park Avenue South
New York, N.Y. 10016
USA

or any United Nations bookstore.

CMC NOTES

Very occasionally, in response to a special interest expressed by German-language church groups involved in health care, CMC has brought out a special German-language issue of CONTACT. The first of these was the Oktober 1978 Sonderausgabe "Die Kirchen und die Behinderten: neue Ansätze, die Isolation zu durchbrechen". Now, the two recent issues of CONTACT focusing on disability and rehabilitation have been combined into one special German issue, the **August 1981 Sonderausgabe «Das Internationale Jahr der Behinderten. Uneingeschränkte Partizipation und Gleichberechtigung".** A third CONTACT issue, that of October 1978 (No. 47 on "Relationships — the Third Dimension of Medicine" by Dr Paul Tournier, was translated and published by a group in Germany as **"Die personale Beziehung — Dritte Dimension der Medizin".**

These special issues are available from the Christian Medical Commission.

Erratum

Most of the readers of CONTACT have already received the Article 11 which was omitted from the International Code of Marketing of Breastmilk Substitutes, printed in the previous issue of CONTACT (No. 62). In case you did not receive that missing article, it is reproduced here and should follow the Article 10 of the Code, which is found on page 18 of that issue of CONTACT.

Notice to CONTACT Subscribers re address changes

When advising us of any change or correction to your address, please do not forget to send us one of our old mailing labels on which your old, or incorrect, address appears. This makes updating/correcting your address a much easier task for us. Thank you.

Article 11 Implementation and monitoring

11.1 Governments should take action to give effect to the principles and aim of this Code, as appropriate to their social and legislative framework, including the adoption of national legislation, regulations or other suitable measures. For this purpose, governments should seek, when necessary, the cooperation of WHO, UNICEF and other agencies of the United Nations system. National policies and measures, including laws and regulations, which are adopted to give effect to the principles and aim of this Code should be publicly stated, and should apply on the same basis to all those involved in the manufacture and marketing of products within the scope of this Code.

11.2 Monitoring the application of this Code lies with governments acting individually, and collectively through the World Health Organization as provided in paragraphs 6 and 7 of this Article. The manufacturers and distributors of products within the scope of this Code, and appropriate nongovernmental organizations, professional groups, and consumer organizations should collaborate with governments to this end.

11.3 Independently of any other measures taken for implementation of this Code, manufacturers and distributors of products within the scope of this Code should regard themselves responsible for monitoring their marketing practices according to the principles and aim of this Code, and for taking steps to ensure that their conduct at every level conforms to them.

11.4 Nongovernmental organizations, professional groups, institutions, and individuals concerned should have the responsibility of drawing the attention of manufacturers or distributors to activities which are incompatible with the principles and aim of this Code, so that appropriate action can be taken. The appropriate governmental authority should also be informed.

11.5 Manufacturers and primary distributors of products within the scope of this Code should apprise each member of their marketing personnel of the Code and of their responsibilities under it.

11.6 In accordance with Article 62 of the Constitution of the World Health Organization, Member States shall communicate annually to the Director-General information on action taken to give effect to the principles and aim of this Code.

11.7 The Director-General shall report in even years to the World Health Assembly on the status of implementation of the Code; and shall, on request, provide technical support to Member States preparing national legislation or regulations, or taking other appropriate measures in implementation and furtherance of the principles and aim of this Code.